CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE

BOARD OF PODIATRY

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE:DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

PODIATRIC PHYSICIAN IN-TRAINING APPLICATION
INSTRUCTION SHEET

General Information

File this application if you are a Podiatric Physician participating in an:

- In-state Delaware residency program, ***or***
- Out-of-state residency program that has a rotation of 45 days or longer in Delaware.

As a Podiatrist In-Training licensee, you are limited to the practice of medicine within the hospital where you are employed except for any outside medical duties that may be assigned as part of the residency program. The outside duties must be performed under the supervision of a fully licensed podiatric physician.

Requirements for All Applicants

☐ Submit completed, signed and notarized *Application for Podiatric Physician In-Training Application*.

☐ Enclose the non-refundable processing fee by check or money order made payable to "State of Delaware."

☐ Arrange for the Board office to receive an official transcript sent *directly* from your school of podiatric medicine to Board office.

- If you have not graduated at the time of application, arrange for the Board office to receive a letter from the school. The letter must attest that you are in good academic standing and state your expected completion date and degree.

☐ Complete the Criminal History Record Check Authorization form to request State of Delaware and Federal Bureau of Investigation criminal background checks. Follow the instructions on the authorization form to arrange to be fingerprinted.

☐ Arrange for the Board office to receive score reports sent directly from the following exam services:

- For scores on the American Podiatric Medical Licensing Examinations (APMLE) Parts I and II, see www.nbpme.org.
- For scores on the APMLE Part III, see www.fpmb.org.

☐ Arrange for the Board office to receive verification of licensure from *each* jurisdiction (state, U.S. territory or District of Columbia) in which you hold, or have *ever* held, a license to practice podiatric medicine, sent *directly* from the state to the Board office.

☐ If you have never been issued a U.S. Social Security Number (SSN), submit a *Request for Exemption from Social Security Number Requirement*.
The Privacy Act of 1974, Section 7, requires the following information to be given to all applicants: Applicants for any Delaware professional or occupational license, permit, registration or certificate (other than Gaming permits) are required to provide a U.S. SSN (29 *Del. C.* §8735(m)). The Division of Professional Regulation uses the SSN primarily to verify identity and safeguard personal information. It may also be used to enforce child support obligation (13 *Del. C.* §2216) and for other lawful purposes.

☐ Arrange for your Resident Program Director and Supervising Physician to complete and sign the *Residency Program Director's Affidavit* included with application.

Reporting Requirement

You must notify the Board office within three days after you complete or withdraw from the residency program.

CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE

BOARD OF PODIATRY

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE:DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

PODIATRIC PHYSICIAN IN-TRAINING APPLICATION

IDENTIFYING AND CONTACT INFORMATION

1. Name: _____ _____ _____
   Last/Family First Middle

2. Other Names Used: None ☐ _____ _____ _____

3. Date of Birth (month/day/year): _____ Gender: Male ☐ Female ☐

4. Have you been issued a U.S. Social Security Number? Yes ☐ No ☐ **If yes, enter your SSN:** _____
   If no, you must file a *Request for Exemption from Social Security Number Requirement*.

5. Address: _____
   Street

   _____ _____ _____
   City State Zip Code

6. Day Phone: _____ Email: _____ None ☐

EDUCATION AND EXAMINATIONS

7. Enter the following information about your medical school:

   Name: _____ Department: _____

   Graduation Date: _____ Check one: Actual Date ☐ or Expected Date ☐

   Address: _____

   If you have graduated, arrange for your school to send an official transcript *directly* to the Board office. If you have not yet graduated, arrange for the school to send a letter directly to the Board office. The letter must attest that you are in good academic standing and state your expected completion date and degree.

8. Enter the following information about your residency:

   Training Institution: _____ Department: _____

   Address: _____
   Street

   _____ _____ _____
   City State Zip Code

   Phone: _____ Date Training Expected to Begin: _____

9. Are you, or have you been, affiliated with any hospitals? Yes ☐ No ☐ If yes, list your hospital affiliations. If you need more room, attach a separate list with the same information.

HOSPITAL	ADDRESS	SERVICE DATES

10. Have you taken and passed the American Podiatric Medical Licensing Examinations Parts I, II, and III? Yes ☐ No ☐ If yes, enter the requested information about your exams:

Request the exam service to send score reports *directly* to the Board office.

EXAMINATION	SCORE	EXAM DATE
APMLE Part I		
APMLE Part II		
APMLE Part III		

LICENSURE AND PRACTICE HISTORY

11. Have you ever been granted a podiatric or other healthcare license by any jurisdiction (U.S. state, territory or District of Columbia)? Yes ☐ No ☐ If yes, complete the following for all licenses. Use a separate sheet if necessary.

LICENSE TYPE	LICENSE NUMBER	ISSUING JURISDICTION	EFFECTIVE DATES

Arrange for the Board office to receive a license verification from *each* jurisdiction listed above, sent *directly* from the state to the Board office.

DISCLOSURES

12. Have you received any administrative penalties regarding your practice of podiatry in any jurisdictions – such as fines, formal reprimands, license suspension or revocation (except for non-payment of fees), probationary limitations – or have you been a party to a consent agreement containing conditions placed by a board on your professional conduct and practice, including any voluntary surrender of a license? Yes ☐ No ☐ **If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents**.

13. Have you ever had a podiatric license revoked, suspended, limited, or placed on probation? Yes ☐ No ☐ **If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.**

14. Have you ever had a disciplinary action taken against you by a Podiatric Medical Society? Yes ☐ No ☐ **If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.**

15. Has a hospital ever changed your privileges as a result of a disciplinary action? Yes ☐ No ☐ **If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.**

16. Are any charges or complaints pending against you in any jurisdiction, or are you currently under investigation for unprofessional conduct, professional misconduct, or malpractice? Yes ☐ No ☐ **If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.**

17. Have you ever been denied a narcotic license (controlled substance registration) or had such license modified, restricted, suspended, canceled, or revoked, or have you ever prescribed narcotic drugs unlawfully? Yes ☐ No ☐ **If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.**

18. Have you ever had any action taken against you by the Narcotics Bureau of the Treasury Department, the Drug Enforcement Agency of the Department of Justice, or any state's Narcotic Agency in this country or any other country? Yes ☐ No ☐ If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.

19. Have you ever:
    - Engaged in the practice of podiatric medicine without a license? Yes ☐ No ☐
    - Employed or knowingly cooperated in fraud or material deception to acquire a podiatric license? Yes ☐ No ☐
    - Impersonated another person holding a podiatric license? Yes ☐ No ☐
    - Allowed another person to use your podiatric license? Yes ☐ No ☐
    - Aided or abetted anyone not licensed as a podiatrist to represent him or herself as a podiatrist? Yes ☐ No ☐

    If yes to any one of the above, explain fully on a separate sheet of paper. Provide copies of all relevant documents.

20. Have you ever entered into a settlement, or had a verdict rendered against you, in a malpractice action? Yes ☐ No ☐ **If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents**.

21. Are you now, or within the last three years have you been, dependent upon the use of alcohol, stimulants, or habit-forming drugs or alcohol or been treated or disciplined for their use? Yes ☐ No ☐ **If yes, explain fully on a separate sheet of paper. Provide copies of all relevant documents.**

22. Have you had either a mental or physical illness which interfered with your practice for over a month? Yes ☐ No ☐ **If yes, explain fully on a separate sheet of paper.**

23. Are you currently physically and mentally *capable* of practicing podiatric medicine and surgery according to generally accepted standards? Yes ☐ No ☐ **If no, continue with the next question. If yes, skip to the DUTY TO REPORT section.**

24. Do you agree to submit to an examination to determine such capability as the Board may deem necessary? Yes ☐ No ☐

DUTY TO REPORT

25. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** obligation to file a written report with the Board of Medical Licensure and Discipline within 30 days if you have any reason to believe that a medical practitioner *other than yourself* is (or may be) guilty of unprofessional conduct as defined in 24 *Del. C.* §1731 OR that he/she is (or may be):
    - medically incompetent
    - mentally or physically unable to engage safely in the practice of medicine
    - excessively using or abusing drugs including alcohol.

    I certify that I have read and understand the provisions of 24 *Del. C.* §1730, 24 *Del. C.* §1731 and 24 *Del. C.* §1731A and that I understand my *duty to report*. Yes ☐ No ☐

26. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** obligation to make an immediate oral report to the Department of Services for Children, Youth and Their Families if you know of, or you suspect, child abuse or neglect under Chapter 9 of Title 16 and to follow up with any requested written reports.

    I certify that I have read and understand 16 *Del. C.* §903 and that I understand my *duty to report*. Yes ☐ No ☐

27. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** duty to **self report** when your podiatrist license in another jurisdiction has been subject to discipline or has been surrendered, suspended or revoked.

    I certify that I have read and understand 24 *Del. C.* §515 (a)(9) and that I understand my *duty to self report*. Yes ☐ No ☐

To ensure consideration of your license application at the next Board meeting, the Board office must receive all of these items *no later than* 4:30 PM ten full working days before the Board's meeting date:

- **Completed, signed and notarized application form**
- **Fee payment**
- **All required supporting documentation.**

Applications that are not complete within 12 months of filing may be considered abandoned and discarded. If your application is approved by the Board, please allow 4-8 weeks to receive your license.

AFFIDAVIT

I certify that I meet all the requirements for licensure specified in 24 *Del. C.* §508(a)(1) through (a)(7), except for completion of the residency program required by §508(a)(2). *I further certify that I intend to limit myself solely to practice within the hospital of my residency or the performance of such medical duties outside the hospital that may be assigned to me as part of the residency program.*

APPLICANT SIGNATURE: _____ Date: _____

State of_____, County of _____

Sworn and subscribed before me this _____day of _____2_____.

Notary Public Signature: _____

SEAL

My Commission Expires: _____

APPLICATIONS THAT ARE INCOMPLETE, UNSIGNED, NOT NOTARIZED OR NOT ACCOMPANIED BY THE REQUIRED FEE WILL BE REJECTED.

CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE

BOARD OF PODIATRY

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE:DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

RESIDENCY PROGRAM DIRECTOR'S AFFIDAVIT

Name of Applicant for Podiatric In-Training License: _____

RESIDENCY PROGRAM DIRECTOR

The residency program director for the applicant's training institution completes this section in the presence of a notary public.

Printed Name of Residency Program Director: _____

Program Director's Delaware License No: _____

- I verify that the above-named applicant will be participating in a training program at:

  Name of Institution: _____ Start Date (month/day/year): _____

- I verify that the applicant will be participating in this training program under the supervision of a fully licensed podiatric physician in the State of Delaware.

- I further verify that the applicant's credentials have been reviewed and approved.

Signature of Residency Program Director: _____ Date: _____

State of_____, County of _____

Sworn and subscribed before me this _____ day of _____ 2_____

Signature of Notary Public: _____

SEAL

My Commission Expires: _____

SUPERVISING PHYSICIAN

The applicant's supervising physician completes this section.

Printed Name of Supervising Physician: _____

Delaware License No: _____

I accept responsibility for the practice of medicine and surgery of this applicant in this institution.

Signature of Supervising Physician: _____ Date: _____

Instructions for Requesting a Criminal Background Check

Both State of Delaware and Federal Bureau of Investigation criminal background checks are required.

Applicant Notification

Your fingerprints will be used to check the criminal history records of the Federal Bureau of Investigation (FBI). You have the opportunity to challenge the accuracy of the information contained in the FBI identification record. See Title 28, CFR 16.34 for the procedure to obtain a change, correction or update in the FBI record.

Locations

Kent County – Primary Facility
State Bureau of Identification
Blue Hen Mall & Corporate Center
655 S. Bay Rd. Suite 1B
Dover, DE 19901
Walk-ins accepted: Mon 8:30 am – 6:30 pm, Tue - Fri 8:30 am – 3:30 pm
Customer Service: (302) 739-2134

New Castle County - Satellite Facility
State Police Troop Two
100 LaGrange Ave
Newark, DE 19702
(between Rts. 72 and 896 on Rt. 40)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Sussex County – Satellite Facility
Thurman Adams State Service Center
546 S. Bedford Street, Rm. 202
Georgetown DE 19947
(across from DelDOT & Troop 4)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Applicants in Delaware

1. If you are using the New Castle County or Sussex County locations, call **(800) 464-HELP (4357)** to schedule an appointment. No appointments are needed at the Kent County location.

2. Take the completed *Authorization for Release of Information* form to one of the offices listed above with the fee of $65.00, to cover both the State of Delaware and Federal Bureau of Investigation criminal checks. Money orders and credit cards other than American Express are accepted at all locations. New Castle and Kent Counties accept cash; Sussex County does not accept cash. ***Personal checks are not accepted in any county.*** As fees are subject to change, contact the agency where you plan to submit your forms for current fees.

Applicants Not in Delaware (including Out-of-State or Outside the United States)

1. Your local police agency can fingerprint you. All types of fingerprint cards are accepted. Or, you may print a FD-258 fingerprint form available on the FBI website at www.fbi.gov – click *Services*, then *Identity History Summary Checks*, then scroll down to Option 1, Step 2, and click the link for *standard fingerprint form (FD-258)*. You may print the form on regular paper.

2. Your *Authorization for Release of Information* form and the fingerprint card must be complete. If identifying information is missing (such as name, date of birth, race, gender, etc.), your form will be returned.

3. ***Mail*** the *Authorization* form, fingerprint card, and *certified* check or money order ***(personal checks are not accepted)*** for $65.00 made payable to "Delaware State Police" to:

Delaware State Police
State Bureau of Identification (SBI)
PO Box 430
Dover, DE 19903-0430

DO NOT SEND THIS FORM OR FEE TO YOUR PROFESSION'S BOARD OFFICE.

DO NOT SEND THIS FORM OR FEE TO THE DIVISION OF PROFESSIONAL REGULATION.

⇨ALLOW FOUR WEEKS FOR RECEIPT OF RESULTS.

Revised 9/2017

CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

AUTHORIZATION FOR RELEASE OF INFORMATION

CRIMINAL HISTORY RECORD CHECK FOR PROFESSIONAL LICENSURE APPLICANTS

Please print or type all information in black ink.

Check the type of license for which you are applying:

- ☐ Adult Entertainment
- ☐ Charitable Gaming Vendor
- ☐ Chiropractic
- ☐ Dental
- ☐ Funeral
- ☐ Massage
- ☐ Medical (Physicians, Physician Assistants, Respiratory Care Practitioners, Eastern Medicine Practitioners, Acupuncture Practitioners, Genetic Counselors, Polysomnographers, Midwifery Practitioners (CM, CPM))
- ☐ Mental Health (LPCMH, LCDP, LMFT, LAPCMH, LAMFT)
- ☐ Nursing (RN, LPN, APRN)
- ☐ Nursing Home Administrator
- ☐ Occupational Therapy
- ☐ Optometry
- ☐ Pharmacy (includes key personnel of facilities licensed by Board of Pharmacy)
- ☐ Physical Therapy/Athletic Trainer
- ☐ Podiatry
- ☐ Psychology
- ☐ Real Estate Appraiser (includes Appraisal Management Company)
- ☐ Speech/Hearing
- ☐ Social Work
- ☐ Texas Hold'em Individual

Print your current full name:

_____ _____ _____ _____
Last Name First Name Middle Initial Suffix (e.g., Jr., Sr.)

Enter all other names you have used in the past (including, but not limited to, maiden name, former married names, alternative spellings):

1. _____
2. _____
3. _____
4. _____

As an applicant, I authorize release of any and all information that you have concerning my **CRIMINAL HISTORY RECORD INFORMATION**. I hereby release you, your organization, the State of Delaware and others from any liability or damage which may result from furnishing this information:

SIGNATURE OF PERSON PRINTED: _____ **Date**: _____

Phone: Home _____ Work _____

Mail the results of my criminal history request to:

Division of Professional Regulation
861 Silver Lake Boulevard, Suite 203
Dover DE 19904
SLC D420A

USE OF CRIMINAL HISTORY RECORD INFORMATION IS RESTRICTED BY LAW AND SHALL BE LIMITED TO THE PURPOSE FOR WHICH IT WAS GIVEN. MISUSE CONSTITUTES A CRIMINAL VIOLATION.

Revised 9/2017